

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10760

CERTIFICATE OF DEATH

10260

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x0 Still Pond		d. STREET ADDRESS -----	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Edward	Middle Washington	Last Davis	4. DATE OF DEATH October 9	Month 1957	Day	Year
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1883	9. AGE (in years lost birthday) 73 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. HOURS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Payne Davis		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-20-5126		17. INFORMANT Lola Davis		Address Still Pond, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 482 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Circulatory collapse				INTERVAL BETWEEN ONSET AND DEATH 1 day	
		(b) inanition + delay deatation				5 days	
		(c) intestinal flu & diarrhoea				2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) arteriosclerosis + coronary heart disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Worton, Md.	(County)	(State)	
21. I certify that I attended the deceased from Oct 5, 1957, to Oct 9, 1957, that I last saw the deceased alive on Oct 8, 1957, and that death occurred at 11:55 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Florence Deringer Joyce M.D.							
ACTUAL SIGNATURE	Florence Deringer Joyce				DATE SIGNED 10/9/57		
PHYSICIAN'S NAME (Type)		Florence Deringer Joyce		Worton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 10/12/57	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery	22d. LOCATION (City, town, or county) Still Pond, Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR DATE 10/10/57	24b. REGISTRAR'S SIGNATURE E. Kennedy Jones		

BRONWELL—2753430. THE MELANISTIC FORM OF THE BROWN

PUREAU Y. R.

OCT 31 1957

REGELIV ED

Robert. Morris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10761 CERTIFICATE OF DEATH

10761 207

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Kent				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 3 hours		3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		d. STREET ADDRESS Mill St. 210				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Anthony DiGiuseppe		First	Middle	Last	4. DATE OF DEATH 10/21/57	Month 10	Day 21	Year 1957		
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 4, 1889	9. AGE (In years (at birthday) 68 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothing		10b. KIND OF BUSINESS OR INDUSTRY Tailor		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Enrico DiGiuseppe		14. MOTHER'S MAIDEN NAME Teresa		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 420.1		16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Anthony DiGiuseppe
										Address 210 Mill St. Chestertown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 2 months								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary Thrombosis								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b)		DUE TO Coronary arterio sclerosis several years								
DUE TO Patient was convalescing and had a recurrence of the thrombosis, the day of death. (c)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Sept. 10, 1956, to Oct. 21, 1957, that I last saw the deceased alive on Oct. 21, 1957, and that death occurred at 9:15 A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Chestertown, Md.								
ACTUAL SIGNATURE Robert W. Farr		DATE SIGNED 10/21/1957								
PHYSICIAN'S NAME (Type) Robert W. Farr										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/24/57		22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cem.		22d. LOCATION (City, town, or county) Prince George Co. Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE 22 1957		24b. REGISTRAR'S SIGNATURE Clara Barnes				

THE CALIFORNIA STATE DEPARTMENT OF HEALTH—DIVISION OF DEATH
CERTIFICATE OF DEATH

BUREAU V. S.

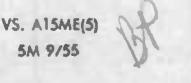
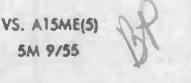
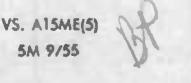
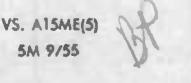
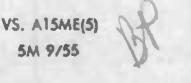
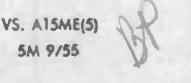
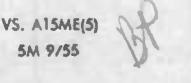
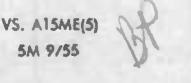
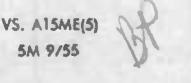
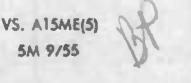
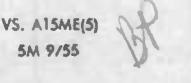
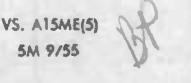
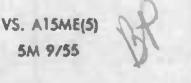
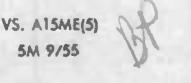
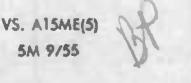
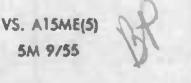
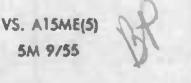
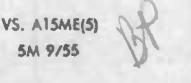
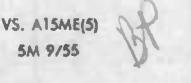
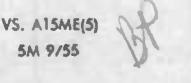
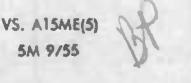
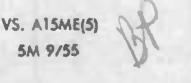
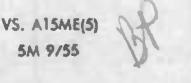
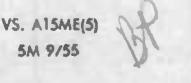
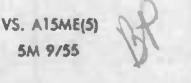
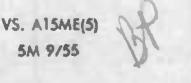
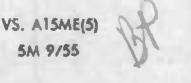
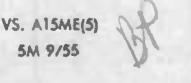
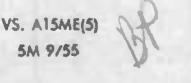
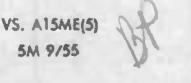
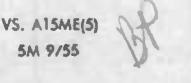
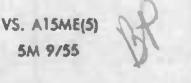
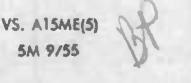
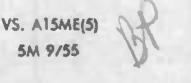
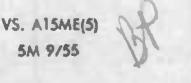
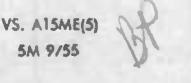
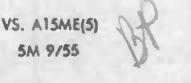
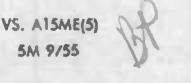
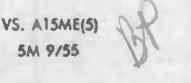
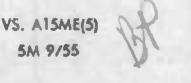
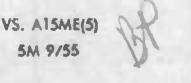
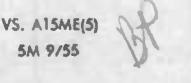
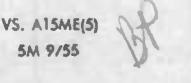
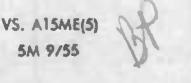
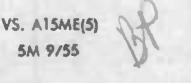
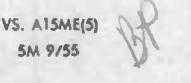
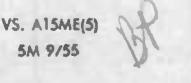
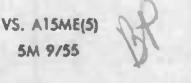
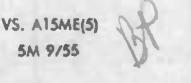
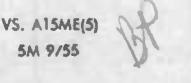
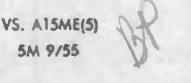
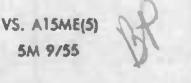
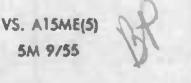
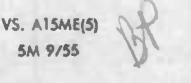
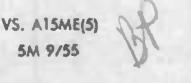
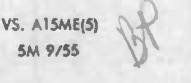
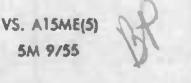
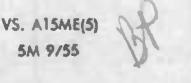
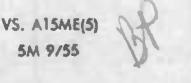
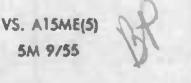
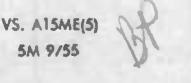
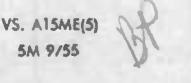
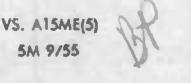
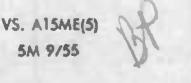
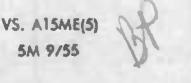
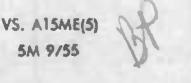
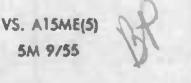
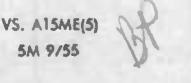
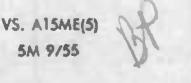
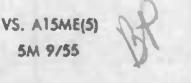
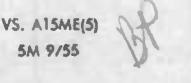
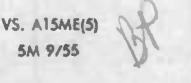
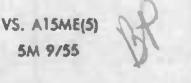
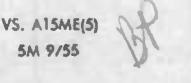
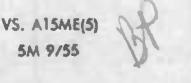
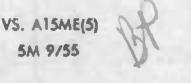
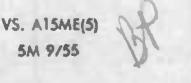
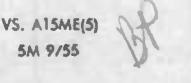
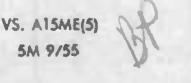
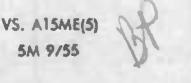
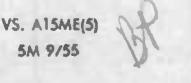
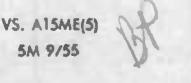
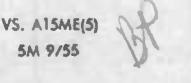
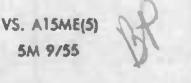
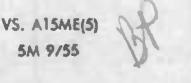
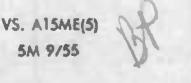
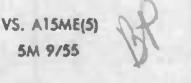
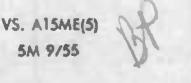
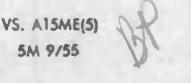
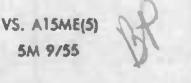
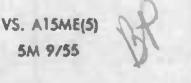
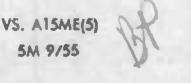
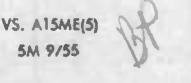
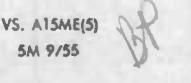
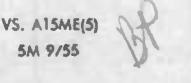
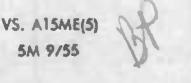
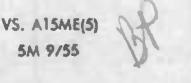
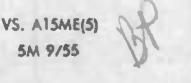
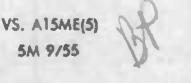
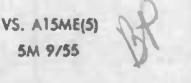
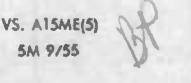
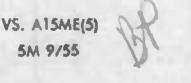
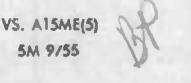
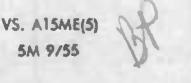
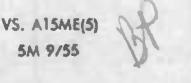
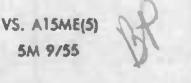
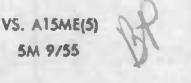
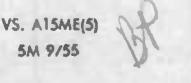
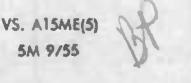
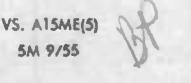
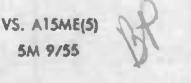
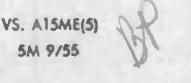
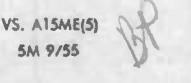
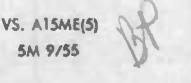
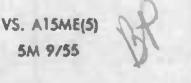
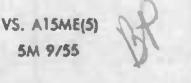
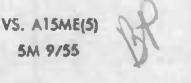
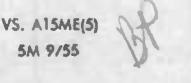
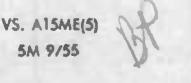
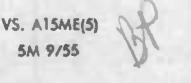
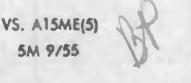
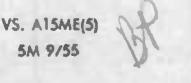
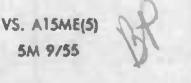
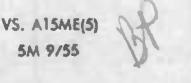
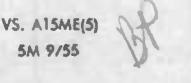
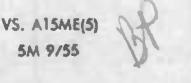
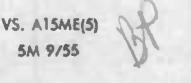
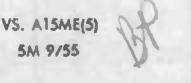
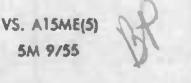
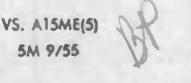
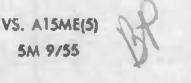
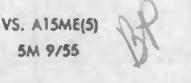
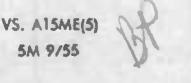
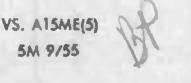
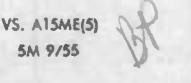
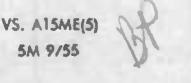
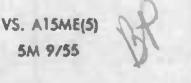
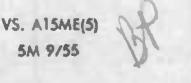
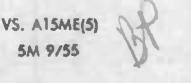
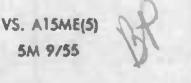
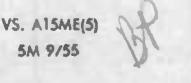
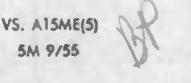
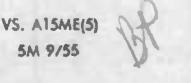
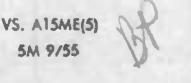
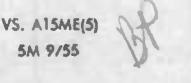
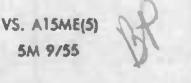
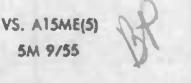
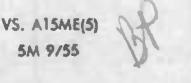
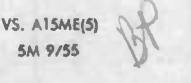
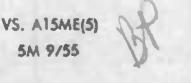
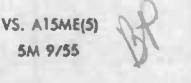
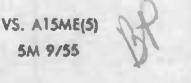
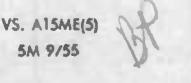
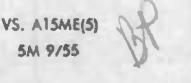
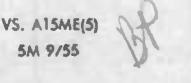
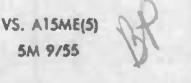
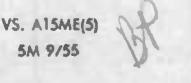
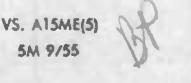
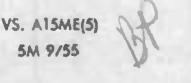
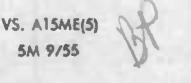
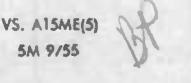
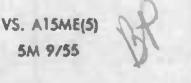
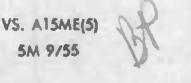
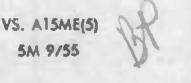
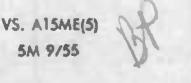
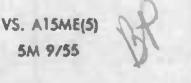
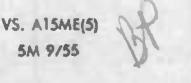
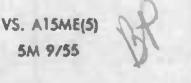
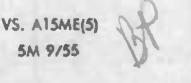
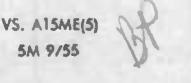
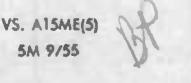
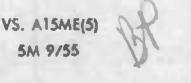
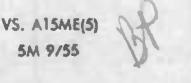
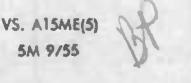
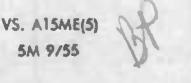
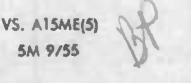
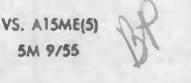
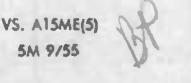
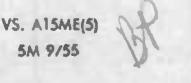
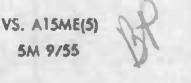
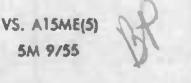
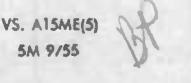
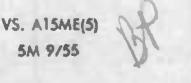
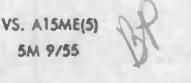
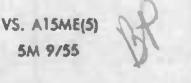
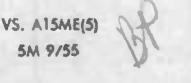
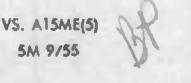
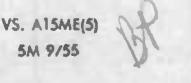
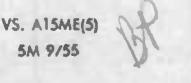
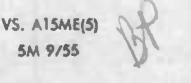
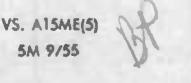
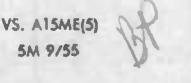
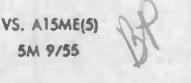
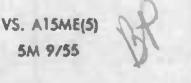
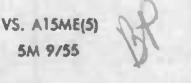
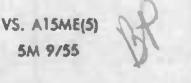
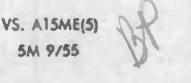
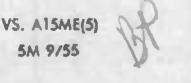
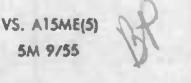
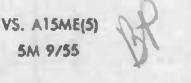
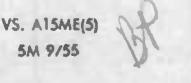
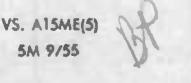
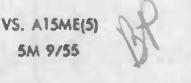
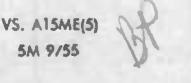
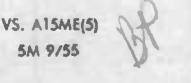
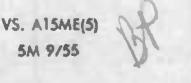
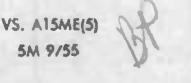
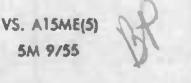
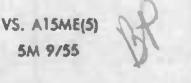
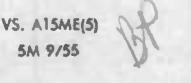
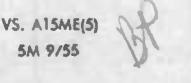
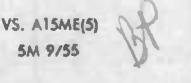
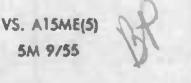
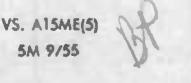
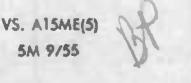
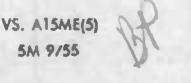
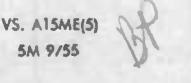
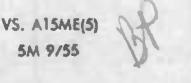
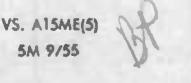
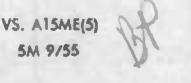
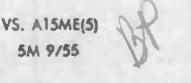
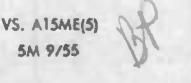
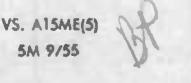
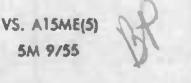
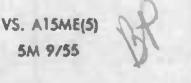
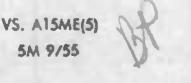
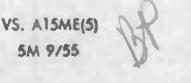
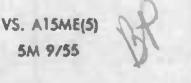
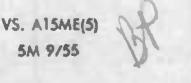
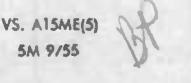
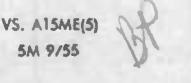
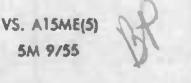
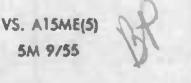
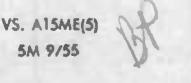
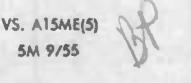
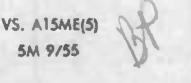
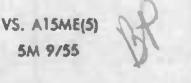
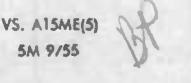
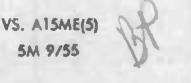
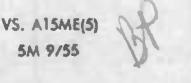
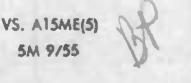
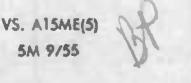
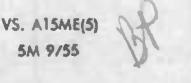
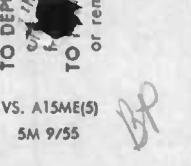
OCT 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be added to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the remains prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55



IN THE STATE OF CALIFORNIA - A CERTIFICATE OF DEATH

BUREAU X. S.
RECEIVED
OCT 17 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10763

10763

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY KENT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE N.Y.		b. COUNTY ORANGE.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		c. LENGTH OF STAY IN 1b 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CORNWALL		d. STREET ADDRESS Old West Point Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR/INSTITUTION Kent Queen Anne Hosp.				d. STREET ADDRESS Old West Point Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES E		First	Middle	Last	4. DATE OF DEATH HAL	Month	Day	Year	
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 3, 1880	9. AGE (In years last birthday) yrs. 77	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY FARM OWNER		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry Haal		14. MOTHER'S MAIDEN NAME Hannah. Owens				Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT HOSPITAL CHART					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Concussion INTERVAL BETWEEN ONSET AND DEATH 825X DUE TO 5 days.									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Skull Fracture.									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Crash.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. Oct 9 1957 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		(City or town) Que. Anne, Md		(County) Ocean	(State) Md
21. I certify that I attended the deceased from Oct 9 , 1957, to Oct 14 , 1957, that I last saw the deceased alive on Oct 14 , 1957, and that death occurred at 11:00 P.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) CHesapeake, Md	
ACTUAL SIGNATURE A. J. Keefe								DATE SIGNED Oct 14, 1957	
PHYSICIAN'S NAME (Type) A. J. Keefe, Jr. M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 17		22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn		22d. LOCATION (City, town, or county) Newburgh		(State) N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Elmer L. Lane		ADDRESS Church Street		24a. REC'D BY REGISTRAR Oct 16 1957		24b. REGISTRAR'S SIGNATURE Clarke Bussey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 1 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME

BUREAU Y. S

OCT 16 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10764

10764

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Worton R.F.D. #1 Box 30			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Daisy	Middle Howard	Last	4. DATE OF DEATH October 22 1957	Month	Day	Year
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1896	9. AGE (In years from birthday) 60 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Daniel		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-22-8846		17. INFORMANT Arthur Howard		Address Worton R.F.D. Box 30	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 576x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO DUE TO C		Post oper. shock				INTERVAL BETWEEN ONSET AND DEATH 14 hrs.	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Respiratory		Post op. intestinal obstruction				24 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chestertown, Md.		(County) (State)	
21. I certify that I attended the deceased from Oct. 20, 1957, to Oct. 23, 1957, that I last saw the deceased alive on Oct. 22, 1957, and that death occurred at 7:05 A.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) M.D.		DATE SIGNED 10-23-57	
ACTUAL SIGNATURE A.C. Dick							
PHYSICIAN'S NAME (Type) A.C. Dick							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/26/57		22c. NAME OF CEMETERY OR CREMATORIAL Fountain Cemetery		22d. LOCATION (City, town, or county) Worton Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR DATE 10/24/57		24b. REGISTRAR'S SIGNATURE E. Harold Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be stained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 29 1957

REGELVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10765

10772

CERTIFICATE OF DEATH

Reg. Dist. No. 202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Fairlee) Chestertown		c. LENGTH OF STAY IN 1b 8 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Strong Nursing Home		d. STREET ADDRESS 1 High St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret		First	Middle	Lost	4. DATE OF DEATH October 7 1957
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1893	9. AGE (In years lost birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Kent Co. Maryland	
13. FATHER'S NAME G. Allen		14. MOTHER'S MAIDEN NAME Jarman Mary Janex		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Carey Jarman Baltimore Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Cerebral vascular accident		INTERVAL BETWEEN ONSET AND DEATH 6 hours	
(b) generalized arteriosclerosis & hypertension DUE TO (c)				2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) chronic rheumatic heart disease				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1957, to October 7, 1957, that I last saw the deceased alive on October 7, 1957, and that death occurred at 3:20 p.m. from the causes and on the date stated above. ACTUAL SIGNATURE Florence Dieringer Joyce M.D. ADDRESS (Street, city or town, state) Worton, Maryland DATE SIGNED 10/7/57 PHYSICIAN'S NAME (Type) Florence Dieringer Joyce m.d.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 9, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Chester Cem.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE 3079 1957	
VS A15 (4) 15MA 9/55				24b. REGISTRAR'S SIGNATURE Clarissa Bracey	

BUREAU V.

OCT 9 1957

REFUGEE FED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10766

Reg. Dist. No. 202

10773

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural Chestertown		C. LENGTH OF STAY IN 1b		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Route 289 near Chestertown, Md.		Transect		d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	12. CITIZEN OF WHAT COUNTRY?			
Male		Colored	WIDOWED <input type="checkbox"/>	Divorced <input type="checkbox"/>	Sept 16, 1931	26 yrs.	Months Days Hours Min.	U. S. A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Laborer		various		Queen Anne Co. Md.		U. S. A.					
13. FATHER'S NAME		Theodore Kennedy		14. MOTHER'S MAIDEN NAME		Hilda Tilghman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
824X		214-308293		Barbara Kennedy		Church Hill, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Accidental cause - probably drowning						a few minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO							
		(c)		DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		External signs of injury. Was lying face down in water						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY 1/2 Hour p. m. 10/19 1957		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Chestertown		(County) Kent	(State) Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE ROBERT W. FARR		DATE SIGNED 10/19/57									
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 23, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Church Hill Cem.		22d. LOCATION (City, town, or county) Church Hill, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DCT 22 1957		24b. REGISTRAR'S SIGNATURE Clara S. Barnes					

BUREAU V. S.

OCT 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12008

10774

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. LENGTH OF STAY IN 1b X2 Rock Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Helen Middle Maria Last Kirby		4. DATE OF DEATH October 29 Day 19 Year 57	
S. SEX Fem	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> April 10-1878	9. AGE (In years last birthday) yrs. 79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	10c. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Joseph Kirby--257 Main Street--Elkton, M Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		INTERVAL BETWEEN ONSET AND DEATH 420.1 Hypertension Arterio Sclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.	20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1</u> , 1957, to <u>Oct 26</u> , 1957, that I last saw the deceased alive on <u>Oct 26</u> , 1957, and that death occurred at <u>Rock Hall</u> , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state)		DATE SIGNED <u>Oct 29/57</u>	
ACTUAL SIGNATURE <u>BERBERT C. Nitsch</u>	M.D. <u>Rock Hall</u>		
PHYSICIAN'S NAME (Type) <u>BERBERT C. Nitsch</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Chestertown</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Maryland</u>
22a. BURIAL, CREMATION, REMOVAL (SPECIFY) Oct. 29	22b. DATE THEREOF Oct. 29	22c. NAME OF CEMETERY OR CREMATORIAL Chester	22d. LOCATION (City, town, or county) (State) Chestertown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar S. Lane</u>		ADDRESS Church Hill, Maryland	24a. REC'D BY REGISTRAR DATE <u>Oct 29/57</u>
			24b. REGISTRAR'S SIGNATURE <u>Elmer B. Burgess</u>

WISCONSIN STATE DEPARTMENT OF HEALTH - FALMOUTH, WI
CERTIFICATE OF DEATH

BUREAU V. S

NOV 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10765

CERTIFICATE OF DEATH

10767
Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Kent</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent + Queen Anne</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>William</u>	Middle <u>E</u>	Last <u>LEARY</u>
4. DATE OF DEATH	Month <u>Oct</u>	Day <u>24</u>	Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 13, 1879</u>
9. AGE (In years last birthday) yrs. <u>77</u>	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS. Days <u>0</u>	12. IF UNDER 24 HRS. Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>hardware</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Isaac Leary</u>	14. MOTHER'S MAIDEN NAME <u>Virginia Martin</u>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>	
16. SOCIAL SECURITY NO. <u>213-12-5245</u>		17. INFORMANT <u>WM L. LEARY</u>	Address <u>Rock Hall, Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO <u>334X</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>aortic insufficiency</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
<u>19</u>			
21. I certify that I attended the deceased from <u>10/16</u> , 19 <u>57</u> , to <u>10-24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-24</u> , 19 <u>57</u> , and that death occurred at <u>3:30</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Farr</u>	M.D.	ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u>	DATE SIGNED <u>10/24/57</u>
PHYSICIAN'S NAME (Type) <u>ROBERT W. FARR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 26/57</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Wiley Chapel Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall - Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin L. Williamson - Chestertown, Md.</u>	ADDRESS <u>Oct. 26/57</u>	24a. REC'D BY REGISTRAR <u>Class. Barnes</u>	24b. REGISTRAR'S SIGNATURE

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BUREAU V. S.

OCT 29 1957

REGEIY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10766

CERTIFICATE OF DEATH

10768
Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BRADY		First A.	Middle MANLEY
4. DATE OF DEATH Oct. 25 1957		Last 35	Month Day Year
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 11-1921	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Manley		14. MOTHER'S MAIDEN NAME Eveline Cuban	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ruth Manley - Chestertown		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2		INTERVAL BETWEEN ONSET AND DEATH 18 hrs	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pain pleia past 11 years	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 1957, to Oct. 24 , 1957, that I last saw the deceased alive on Oct. 22 , 1957, and that death occurred at 8:15 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE H.H. Hamilton		ADDRESS (Street, city or town, state) Millington Md	
PHYSICIAN'S NAME (Type) H.H. HAMILTON		DATE SIGNED 10/25/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Oct. 28		22b. DATE THEREOF Oct. 28	
22c. NAME OF CEMETERY OR CREMATORIAL Stonewall		22d. LOCATION (City, town, or county) Harpington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar J. Hare Church Hill Md		24d. REC'D BY REGISTRAR Oct. 29 1957	
ADDRESS		24e. REGISTRAR'S SIGNATURE Clara Barnes	

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 221 10-18-57 ams

10769

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH

o. COUNTY

Kent

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

Maryland

b. COUNTY

Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chestertown

c. LENGTH OF STAY IN 1b

10 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rock Hall

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Kent & Queen Annes

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF DECEASED (Type or print)

First Margie

Middle S

Last McGinnis

4. DATE OF DEATH

Month October

Day 6

Year 1957

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

January 13, 1898

9. AGE (In years lost birthday)

59

yrs.

Months

IF UNDER 1 YEAR

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housework

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Kelley

14. MOTHER'S MAIDEN NAME

Grace Scott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Hospital records & deceased

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

1938

Adenocarcinoma, Grade III, metastatic to liver

INTERVAL BETWEEN
ONSET AND DEATH
KNOWN FOR

peritoneum and left pleural space

z 1 month

(Primary site unknown)

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Doy, Year
Hour o. p. 19
p. m.

20d. INJURY OCCURRED

While
at work Not while
at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

8/15, 1957

Oct 6

1957

21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL
SIGNATURE

Robert W. Farr

ADDRESS (Street, city or town, state)
Chestertown, Md.DATE SIGNED
Oct 6, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 10-9

22b. DATE THEREOF

Wesley

22c. NAME OF CEMETERY OR CREMATORIAL

Rock Hall Ind

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Edgar S. Lane Church Hill Md.

ADDRESS

REC'D BY REGISTRAR
DATE

24b. REGISTRAR'S SIGNATURE

Clara Barnes

ET

CERTIFICATE OF DEATH

BUREAU V. #

OCT 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10770

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent		10769 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown 37					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes				d. STREET ADDRESS 506 Cannon Street					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Lee		First	Middle	Last	4. DATE OF DEATH October	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH September 6 1900	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer & night watchman		10b. KIND OF BUSINESS OR INDUSTRY Cannery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William H. Scott		14. MOTHER'S MAIDEN NAME Sally Vickery Vickery							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-01-9649		17. INFORMANT Patient & hospital records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis						INTERVAL BETWEEN ONSET AND DEATH 3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO Intracranial Hemorrhage(stroke)				6 days			
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260X Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chestertown, Md.		20f. (City or town) (County)		(State)	
21. I certify that I attended the deceased from October 2, 1957 to October 15, 1957 , that I last saw the deceased alive on October 15, 1957 , and that death occurred at 3:15 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert W. Farr</i>						ADDRESS (Street, city or town, state) Chestertown, Md.		DATE SIGNED Oct. 15, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 17, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery		22d. LOCATION (City, town, or county) Chestertown, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE OCT 17 1957		24b. REGISTRAR'S SIGNATURE <i>Class S Barnes</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

31. ЗРОДИЛИСЯ ДЛЯ ВІДОВЛІВАННЯ ТА ПІДСУДЖЕННЯ ЗА ГІДРУГРАДІ.

BUREAU V. 3

OCT 17 1957

REFUGEE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10769

10771

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, Md.		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes		x2 d. STREET ADDRESS Roc kHall, Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Paul		First L	Middle Stevens
4. DATE OF DEATH October 6 1957		Month October	Day 6
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH September 21, 1920		9. AGE (In years lost birthday) 37 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking Compnay	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME K. Jack Stevens		14. MOTHER'S MAIDEN NAME Emma	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 17. INFORMANT	
		Address Hospital records & Mrs Paul Stevens, Rock Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver in with acute hepatic failure DUE TO and/or hepatitis		INTERVAL BETWEEN ONSET AND DEATH 3½ weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) October 6, 1957 (County) Rock Hall (State) Md.	
21. I certify that I attended the deceased from September 26, 1957 , to October 6, 1957 , that I last saw the deceased alive on October 6, 1957 , and that death occurred at 10:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Robert W. Farr PHYSICIAN'S NAME (Type) Robert W. Farr		ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED Oct 6, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 10-9		22b. DATE THEREOF 10-9-1957	
22c. NAME OF CEMETERY OR CEMMATORY Wesley Chapel		22d. LOCATION (City, town or county) Rock Hall Md. STATE Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Jane		24a. REGD. BY REGISTRAR ADDRESS Edgar L. Jane Church Hill Rd., Chestertown, Md. DATE 10-9-1957	
		24b. REGISTRAR'S SIGNATURE Clara Barnes	

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

10770

CERTIFICATE OF DEATH

Reg. Dist. No.

10772
202

1. PLACE OF DEATH a. COUNTY KENT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XOMILLINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT + QUEEN HOSPITAL		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First PATRICIA	Middle Mae	Last WATSON
4. DATE OF DEATH	Month OCT.	Day 13	Year 1957
5. SEX F.	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1953
9. AGE (In years less birthday) yrs.	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES H. WATSON		14. MOTHER'S MAIDEN NAME SARAH JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT SARAH JOHNSON, Millington, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) UnKnown cause		10 day	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.			
DUE TO (c) Probable Overwhelming infection			
DUE TO (c) Pneumonia & Pleural effusion -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/13 , 19 57 , to 10/13 , 19 57 , that I last saw the deceased alive on 10/13 , 19 57 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Maryland DATE SIGNED 10/13/57			
ACTUAL SIGNATURE Thomas J. Solon		M.D.	
PHYSICIAN'S NAME (Type) THOMAS J. SOLON		CHESTERTOWN, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/16/57	
22c. NAME OF CEMETERY OR CREMATORIAL RILEY'S NECK, CEM. MILLINGTON, KENT MD.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Yellow, Millington, Md.		ADDRESS	
24a. REC'D BY REGISTRAR ACT 21 1957		24b. REGISTRAR'S SIGNATURE Clare Hansen	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10773

Reg. Dist. No. 202

10771

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Chestertown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital		d. STREET ADDRESS Kent St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Pricie	Middle Maslin	Last Watson	4. DATE OF DEATH Oct. 9, 1957	Month Oct.	Day 9	Year 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7/16/1877	9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? Usa	
13. FATHER'S NAME John Carvil Maslin		14. MOTHER'S MAIDEN NAME Hannah Ball				Address Chestertown, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Ringgold Strong			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary artery disease, probable infarct				INTERVAL BETWEEN ONSET AND DEATH 20 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Arteriosclerosis				20 years	
		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 481X		Influenza				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-9, 1957, to 10-9, 1957, that I last saw the deceased alive on 10-9, 1957, and that death occurred at 10:30a.m., from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>A. C. Dick</i>		M.D.				DATE SIGNED 10-10-57	
PHYSICIAN'S NAME (Type) A. C. Dick		Chestertown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/11/57		22c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery		22d. LOCATION (City, town, or county) Chestertown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Julius Wells</i>		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE OCT 14 1957		24b. REGISTRAR'S SIGNATURE <i>Clare Barnes</i>	

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 14 1957

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10774

10775

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton		c. LENGTH OF STAY IN 1b life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Butlertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton		d. STREET ADDRESS Butlertown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Edward Whye		First	Middle	Last	4. DATE OF DEATH October 17	Month	Day	Year		
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 25 1886		9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William Whye		14. MOTHER'S MAIDEN NAME Mollie Dorsey		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Henry C. Whye		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 590 X DUE TO Acute Nephritis INTERVAL BETWEEN ONSET AND DEATH 4 months				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO Heart Disease		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from _____		Sept 20 1957 to Oct 17 1957		that I last saw the deceased alive on _____		Chest 17 1957		M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Still Pond Md.		DATE SIGNED
ACTUAL SIGNATURE L. P. Atwell		M.D.		L. P. Atwell		L. P. Atwell		Still Pond Md.		
PHYSICIAN'S NAME (Type) L. P. Atwell		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 20, 57		22c. NAME OF CEMETERY OR CREMATORIAL Butlertown Cemetery		22d. LOCATION (City, town, or county) Worton, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR Oct. 22-57		24b. REGISTRAR'S SIGNATURE Class B. Bassett				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 25 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 2 should be filed with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10776

CERTIFICATE OF DEATH

10775

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton		c. LENGTH OF STAY IN 1b X/1 Worton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Muddy Branch Farm		d. STREET ADDRESS /	
3. NAME OF DECEASED (Type or print) Ralph P. Williams Sr.		4. DATE OF DEATH Oct. 7	Month Year 1957
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7 1888
9. AGE (In years last birthday) 69	10. IF UNDER 1 YEAR Months yrs.	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (State or foreign country) Worton, Kent Co. Md.
13. FATHER'S NAME George T. Williams		14. MOTHER'S MAIDEN NAME Sra M tilda Porter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-34-9236	17. INFORMANT Sarah C. Williams, Worton, Md. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH few minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		coronary insufficiency	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November</u> , 19 <u>56</u> , to <u>Oct. 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct. 7</u> , 19 <u>57</u> , and that death occurred at <u>5:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CHSTERTOWN, MD.</u> DATE SIGNED <u>Oct. 8, 1957</u>			
ACTUAL SIGNATURE <i>R. Lee T. Aker</i>		PHYSICIAN'S NAME (Type) Robert W. Farr, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 10, 57	22c. NAME OF CEMETERY OR CREMATORIY Still Pond Cem.	22d. LOCATION (City, town, or county) (State) Still Pond, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR Oct. 10-1957
			24b. REGISTRAR'S SIGNATURE <i>Clara S. Barnes.</i>

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10776
200

10777

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY KENT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLINGTON		b. COUNTY KENT	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLINGTON X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) LEONARD		4. DATE OF DEATH Oct. 20 1957	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
First M.	Middle W.	Lost Wilson	Month
6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH MARCH 4, 1875	Day
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 82 yrs.	Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BANKER	10b. KIND OF BUSINESS OR INDUSTRY BANK	11. BIRTHPLACE (State or foreign country) MD.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME EDWARD	14. MOTHER'S MAIDEN NAME SARAH	Address MILLINGTON, MD.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 163X	16. SOCIAL SECURITY NO. —	17. INFORMANT MRS. LEONARD Wilson	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO cancer of the lung
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — (c) —	Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Apr. 20, 1957 to Oct. 20, 1957 , that I last saw the deceased alive on Oct. 19, 1957 , and that death occurred on Oct. 20, 1957 , from the causes and on the date stated above.			
ACTUAL SIGNATURE GEZA KORALEWSKI	ADDRESS (Street, city or town, state) MILLINGTON, MD. DATE SIGNED 10-21-57		
PHYSICIAN'S NAME (Type) GEZA KORALEWSKI	22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 10/24/57 22c. NAME OF CEMETERY OR CREMATORIUM MILLINGTON CEM. 22d. LOCATION (City, town, or county) MILLINGTON MD.		
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows. Millington, Md.	24a. RECD BY REGISTRAR NOT 25 10/25/57 24b. REGISTRAR'S SIGNATURE Edward B.		

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STATE OF HAWAII - GOVERNOR

CERTIFICATE OF DEATH

RECEIVED
BUREAU V. S.
OCT 25 1957